Parliamentary brief
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“Projected NHS funding gap in England”

Lords Oral Question
Monday 17 November 2014

The British Medical Association (BMA) is the voice of doctors and medical students in the UK. We are an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year.

Executive Summary

- The NHS in England faces a significant funding gap for the 2015/16 financial year. The service has reached a critical point and the cracks are starting to show.

- A public debate on health service funding is urgently needed, focusing on how to reconcile increasing demand with universal and comprehensive care. This should not target the terms and conditions of the NHS staff needed to deliver this.

- A model for funding health and social care must be agreed, alongside a realistic timetable for implementation, for example over the course of the next two terms of government. Urgent effort must be focused on setting out and agreeing a model for funding and delivery, rather than rushing to implement unsustainable short-term measures.

- Private Finance Initiatives continue to be a drain on the public purse. Deficits have deepened as a result of PFI payments increasing annually whilst hospital income is falling. The Government should directly fund new NHS capital projects, renegotiate PFI contracts and enable existing PFI schemes to be bought out by the NHS.

Background

Despite being given a degree of fiscal protection in spending rounds since the General Election in 2010, the NHS in England has effectively had no real increase in spending between 2010/11 and 2013/14.\(^1\) Over this period of financial constraint doctors and NHS staff have contributed as much as they can to sustaining and improving NHS performance, despite there being no additional investment in the service.

A report from the Nuffield Trust argues that the health service budget is rapidly becoming insufficient and the health service will be unable to continue to deliver the same quality of service without additional resources.\(^2\) Capacity constraints in a number of areas are leading to worsening
performance, recruitment difficulties, and a short-term focus on activity at the expense of finding sustainable solutions to an overall funding shortfall.

**The current financial state of the NHS**

In June 2014 the BBC reported that the NHS in England faces a funding gap of up to £2 billion for the 2015/16 financial year. This funding gap is underlined by figures from Monitor which show a deficit of £1.6 billion. This is highlighted by the financial reports from across the NHS:

- 41 of the 147 Foundation Trusts recorded a deficit at the end of 2013/14, 20 more than the previous year;
- 86 Foundation Trusts reported a deficit in Quarter 1 2014/15;
- 19 English NHS Trusts and 24 Clinical Commissioning Groups (CCGs) were referred to the Secretary of State during 2013/14, mainly on financial grounds; and
- Primary care funding has fallen by more than £9.1 billion in real terms since 2004/5, to 8.5 per cent of the NHS budget by 2011/12 despite over 90 per cent of patient contacts within the NHS being managed within general practice.

In addition to the evidence of the financial pressures in the NHS, service pressures are showing suggesting the health service has now reached a critical point:

- The proportion of inpatients waiting more than 18 weeks from referral to treatment breached the 10 per cent target for the first time in almost three years in February and March 2014. The target was again breached from June to August 2014.
- The national target for A&E, that 95% of patients are seen within four hours, has not been met by major units since July 2013.
- The proportion of patients waiting more than six weeks for a diagnostic test has missed its one per cent target since November 2013.
- The target that 85 per cent of patients should wait no longer than 62 days from an urgent GP referral to first definitive treatment for cancer was missed for the first time in quarter four of 2013/14 and has continued to decline into 2014/15.

The phasing out of the Minimum Practice Income Guarantee (MPIG) is having a profound and destabilising effect on surgeries that provide vital care to patients. Where practices will have to close as a result of the MPIG cut, patients will be left without local GP services.

**Long term funding options for the NHS**

There is a need for a public debate in health service funding, around how to reconcile increasing demand with universal and comprehensive care, without targeting the terms and conditions of the NHS staff needed to deliver this.

The vital role of health improvement and prevention must be recognised in any discussion around funding. This formed part of NHS England’s Five Year Forward View. The BMA considers prevention to be central in helping to address the financial problems facing the NHS. For example, the best way to curb the rising demand for diabetes services is to reduce rates of diabetes. Likewise, healthy ageing is the best way to address the rising costs of dependency among older people. The BMA considers that spending on prevention should rise at least in line with spending on the NHS as a whole. The NHS cannot afford to cope with the burdens that result from inadequate prevention.

Integration between health and between health and social care has been identified as having the potential to help achieve efficiency savings as well as improve services for patients and service users in the medium to long term. The BMA considers that closer integration should be encouraged where evidence shows it can be beneficial to patients and service users. However, it
is not clear that achieving greater integration will necessarily lead to savings in the system, particularly in the short term. Rather, significant up-front investment is likely to be required to facilitate integrated care initiatives and enable shifts to new ways of working.

A model for funding health and social care must be agreed, alongside a realistic timetable for implementation, for example over the course of the next two terms of government. This should be developed in tandem with plans to fill the £30 billion funding gap predicted for the NHS by 2020.¹³ Urgent effort must be focused on setting out and agreeing a model for funding and delivery, rather than rushing to implement unsustainable short-term measures.

The recent report from the Commission on the Future of Health and Social Care in England⁴ (the Barker report) has successfully moved the debate forward by making a set of detailed recommendations on how the funding challenges facing the health and social care systems might be addressed. We agree with the King’s Fund’s assertion that ‘responding to the challenge [the Barker Report] ... sets out should be a top priority for the incoming government’.¹⁵

**PFI agreements in the NHS**

Private Finance Initiatives (PFI) continue to be a drain on the public purse. This is demonstrated through the struggles of the South London Healthcare Trust and Barking, Havering & Redbridge NHS Trust in recent years.¹⁶ This view is supported by the Treasury Select Committee¹⁷ which criticised the use of PFIs for increasing the cost of finance for public investments relative to what would be available to the government if it borrowed on its own account.

Successive governments have attributed deficits in NHS trusts to a ‘legacy’ of PFI debts, but in reality, deficits have deepened as a result of PFI payments increasing annually whilst hospital income is falling. This is because in most PFI contracts annual cash payments are indexed to the rate of inflation so that they rise year by year.¹⁸ NHS hospitals owe £80bn in PFI loan unitary charges – the ongoing costs of maintaining PFI hospitals and paying back the loans. In 2015, trusts will make some £2bn in repayments.¹⁹ This is exacerbating affordability problems at a time of real term reductions in public expenditure.

**The BMA continues to call on the Government to directly fund new NHS capital projects, renegotiate PFI contracts to ensure a better deal for the taxpayer, and enable existing PFI schemes to be bought out by the NHS.**

**The impact of the Health and Social Care Act 2012**

A recent paper²⁰ highlights how costly top-down reorganisation of the NHS has been over the previous decades with “the most recent market initiatives under New Labour and then the Coalition government comprising £3 billion each.” It is for these reasons that the BMA has called for no more top-down reorganisation of the NHS.²¹

Whilst the introduction of the market and various reforms have incurred significant costs to the NHS, the evidence on benefits and patient outcomes is less clear and indeed is hotly contested amongst the research community.²² There is no conclusive proof of either significant benefits or an absence thereof.

**The introduction of the market into the NHS has led to fragmentation and waste with adverse implications for patient safety, quality assurance and training. The cost of establishing and managing competition between multiple providers may create greater costs and complexity for commissioners.**
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References

1 King’s Fund (2014) How is the NHS Performing: July 2014.
6 Royal College of GPs (2014) Waiting times to see a GP now a ’national crisis‘, 26 September 2014.
11 The Minimum Practice Income Guarantee (MPIG) was introduced in 2004 to support GP practices moving to the new General Medical Services contract (nGMS). The MPIG is used to top up the funding of practices to match income levels prior to the introduction of the 2004 contract. The payments made by the MPIG amount to around £116 million annually and are referred to as correction factor payments.